FACT Sheet

WASHINGTON STATE DEPARTMENT OF SOCIAL & HEALTH SERVICES

Child fatality and near fatality reviews honor each child by examining the case

Child abuse and neglect fatalities

Any death of a child is tragic. A child's death is more troubling when that child has been served by the state social service system, and even more so when the death is due to child abuse or neglect at the hands of an adult entrusted to care for that child. We work hard to keep children safe and prevent even a single fatality. We continue to learn from these tragedies by taking a critical look at our own work. From these evaluations, DSHS has made and continues to make improvements, focusing on child safety while keeping families together whenever possible.

Families become involved with the child welfare system when the family is at the worst of times and in crisis. Every day we evaluate parents' abilities to care for their child, but future behavior of parents harming their own children is not always predictable, and we must make reasonable efforts to keep the family together, unless the child is at risk of imminent harm.

Why conduct a child fatality review?

By state law, Children's Administration is required to conduct a fatality review when a child death or near-death injury is suspected to be caused by abuse or neglect, and the child has received services from Children's Administration in the past 12 months. The child fatality review is conducted to honor each child by examining each child's case to identify trends, evaluate training, policies, and social work practice to inform and improve future practice.

With the passage and enactment in 2011 of SHB1105, Children's Administration now focuses on reviewing child fatalities, near fatalities and other critical incidents that are specifically related to suspected child abuse and neglect. Previously, fatality reviews were required for all child fatalities in which a child's death was unexpected, and the child had received child welfare services in the previous 12 months.

What is a child fatality review?

In its limited purpose the Child Fatality Review of a case in which a child has died as a result of abuse and/or neglect or under suspicious circumstances is to evaluate the Department's delivery of services to the family, as well as the system response to the identified needs of the family.

What does the Department do with the review and the recommendations?

This evaluation or review of the Department's services and community response to concerns about child abuse and neglect issues in a family will help to identify possible areas for improvement through education, training, policy and legislative changes.

"Lessons Learned" curriculum is continually updated from the reviews of fatalities and critical incidents. This training is now required for new and seasoned social workers, supervisors and management.

Who participates in the child fatality review?

The fatality review team is made up of individuals who have not had any involvement with the case, and represent areas of expertise that are pertinent to the case. The review committee members may include legislators or representatives from the Office of the Family and Children's Ombudsman.

When is the fatality review due to be completed?

The fatality review must be completed within 180 days following the child's death. The review report must be distributed must be distributed to the appropriate legislative committees and posted online at: http://www.dshs.wa.gov/ca/pubs/fatalityreports.asp.

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For more information about Child Dependency or other Children's Administration topics, please contact:
Sherry Hill, Children's Administration Communications Director: 360-902-7892 or Sherry.Hill@dshs.wa.gov Thomas Shapley, DSHS Public Affairs Senior Director: 360-902-8007 or Thomas.Shapley@dshs.wa.gov or